



Welcome to Our Practice

Referral By _____

Date _____

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____

Sex: Male Female Birth Date _____ Age _____ Driver's Lic # _____

Street _____ City _____ State _____ Zip _____

Home Tel _____ Bus Tel _____ Cell # _____

Soc Sec# _____ Email _____

In case of emergency, please contact _____ Tel _____ Relation _____

SPOUSE / OTHER GUARANTOR INFORMATION

First Name _____ Last Name _____ Relationship _____

Soc Sec # _____ Birth Date _____ Age _____ Driver's Lic # _____

Street _____ City _____ State _____ Zip _____

Home Tel _____ Bus Tel _____ Cell # _____

Employer _____ Employer address _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Type Dental Medical

Insurance Co. Name _____ Insurance Co. Tel _____

Group # _____ Group Name _____ Subscriber ID # _____

Subscriber Name _____ Relationship _____ Soc Sec # _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Type Dental Medical

Insurance Co. Name _____ Insurance Co. Tel _____

Group # _____ Group Name _____ Subscriber ID # _____

Subscriber Name _____ Relationship _____ Soc Sec # _____

MEDICATION & ALLERGIES

Please list any medication(s) you are taking (including natural, herbal, or homeopathic products)

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Medication _____ Dosage _____ Frequency _____

Are you taking blood thinners (*Coumadin, Aspirin*)? Yes No

Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, or Aredia within the past 12 years? Yes No

Are you allergic to, or had a reaction to

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Amoxicillin |
| <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Sodium pentothal/Valum/Other tranq. | <input type="checkbox"/> Soy/Eggs/Yolk | <input type="checkbox"/> Sulfites |

Please list any other medication or antibiotic you are allergic to

Please list any allergies other than drug allergies

Below are for women only (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods or birth control.)

Are you pregnant? Yes No

Expected delivery date _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

I **certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Print Patient Name _____ Patient Signature _____ Date _____

(Parent or Guardian if minor)

Email : _____

Office Policy and HIPPA

Cancellation & Broken Appointments Policy

Two business days (48 hours) advanced notice is required for any change or cancellation of your scheduled appointment. This allows us the time to fill your appointment by others who are in need of dental care.

For patients who cancel their appointments less than 2 business days (48 hours), or don't show up for the appointment, a fee of \$75 will be charged to the account. Please note that your account will only be charged if you do not honor our Cancellation and Broken Appointment Policy.

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. Please give us the same consideration when you need to reschedule or cancel your appointment.

INITIAL _____

Signature Release Statement

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to **Dr. Titus Tang / 59B Dental**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. INITIAL _____

Payment and Financial Policy

All known and estimated co-payments are due at the time services. A returned check is subjected to a \$25 fee.

DENTAL INSURANCE: Our estimates regarding your dental insurance are given as carefully as possible. These estimates are based on current information available and past payment history of insurance companies. However, your insurance carrier will ultimately decide on the benefit to be released. Our financial arrangement will include your estimated dental insurance coverage and you are responsible for the total treatment fee as listed on the treatment page.

Once your insurance company has processed the insurance claim, you will be billed for any outstanding balance. If you have questions about insurance reimbursement, it is your responsibility to contact your insurance provider. Once a claim has been closed your balance is due. Claims will be considered closed, regardless of payment, 120 days from the original date of service. INITIAL _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices and Consent have been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. INITIAL _____

Print Patient Name (*Parent or Guardian if minor*)

Signature of Patient (*Parent or Guardian if minor*)

Date

Smile Evaluation

1. Do you like the way your teeth look? Yes No
Explain: _____

2. Are you happy with the color of your teeth? Yes No
Explain: _____

3. Would you like your teeth to be whiter? Yes No
Explain: _____

4. Would you like your teeth to be straighter? Yes No
Explain: _____

5. Do you have spaces between your teeth that you would like closed?

If so, Upper Lower Both?

6. Would you like your teeth to be longer? Yes No
Explain: _____

7. Do you like the shape of your teeth? Yes No
Explain: _____

8. Do you have missing teeth that you would like replaced? Yes No
Explain: _____

9. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? Yes No

10. If you could change anything about your smile, what would you change?
